



RETREAT ASSISTANCE NETWORK

To identify our neighbors needing assistance, we ask that you complete this survey and return it to Audrey DeLoffi by January 30, 2017.

RESIDENT NAME: _____

Address: _____

Landline: _____ Mobile: _____ Email: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact's Telephone(s): _____

Please circle appropriate answer below

1) Before receiving this mailing, were you aware of RAN services in our community?

Yes No Not Sure

2) If you have a physical issue that prevents you from being totally independent, do you have someone to help you?

Yes No

3) Do you live alone?

Yes No

(Over)

SURVEY CONTINUED

4) If you needed help getting to medical appts, getting groceries, cooking a meal, on a limited basis, would you contact RAN for help?

Yes No Not Sure

5) Would you enjoy a personal visit or telephone call from a friendly visitor?

Yes No Maybe

6) Do you have an upcoming appointment that you would like RAN to help with?

Yes No

7) If you would like to have transportation to an upcoming appointment, please indicate date & time:

Date of Appointment: _____ Time of Appointment: _____

Return Form to: Audrey DeLoffi, 9092 SE Retreat Dr.

THANK YOU!!